New Jersey Department of Health and Senior Services
Health Insurance Continuation Program
PO Box 363
Trenton, NJ 08625-0363

FOR STATE USE ONLY
Record No.

CERTIFICATION BY PHYSICIAN

SECTION I - TO BE COMPLETED BY APPLICANT

Please complete the requested information in Section I. Forward to your physician for completion of Section II. Ask your physician to return the completed form to you.

1. Name (Last, First, MI)	2. Social Security Number
3. Street Address	4. Date of Birth ___ ___ / ___ ___ / ___ ___
5. City, State, Zip Code	6. County

7. Sex
- ☐ Male
- ☐ Female

8. Race/Ethnicity
- ☐ White (Non-Hispanic)
- ☐ Black (Non-Hispanic)
- ☐ Hispanic
- ☐ Asian/pacific Islander
- ☐ American Indian/Aleutian/Native American/Eskimo
- ☐ Other: _____

PERMISSION FOR RELEASE OF INFORMATION

I hereby give permission to my physician to release the requested information to the New Jersey Department of Health and Senior Services for the purpose of determining my eligibility to participate in the Health Insurance Continuation Program.

Signature of Applicant	Date

SECTION II - TO BE COMPLETED BY PHYSICIAN

The individual named above has applied to the New Jersey Department of Health and Senior Services to participate in the Health Insurance Continuation Program. Please provide the following information regarding the above applicant. Return this completed Certification form to the applicant to submit along with the completed Application.

1. Has the applicant (patient) tested positive for HIV? ☐ Yes ☐ No
2. Does the applicant meet CDC criteria for AIDS? ☐ Yes ☐ No
3. Has this case been reported to the NJDHSS, HIV/AIDS Surveillance Unit? ☐ Yes ☐ No
4. Date of the most recent T Helper (CD4+) lymphocyte count test (if test not done use "00/00"; if unknown use "99/99"): ____ ____ / ____ ____ (Month / Year)
   a. Absolute CD4+ lymphocyte count for the above test: _____ cells/mm3
   b. Percent CD4+ lymphocyte count for the above test: _____ %
5. Date of the most recent reactive PPD test (if test not done use "00/00"; if unknown use "99/99"): ____ ____ / ____ ____ (Month / Year)
6. Current TB status:
   - ☐ Evidence of TB, Active, Receiving Treatment
   - ☐ Evidence of TB, Active, No Treatment
   - ☐ Evidence of TB, Active, Treatment Unknown
   - ☐ Evidence of TB, Inactive, Prophylaxis
   - ☐ Evidence of TB, Inactive, No Prophylaxis
   - ☐ No Evidence of TB
   - ☐ Unknown

Name of Physician (Print)	License Number and State
Street Address	County
City, State, Zip Code	Telephone Number
City, State, Zip Code	
Signature	Date

Applicant: Forward this completed Certification by Physician to the Health Insurance Continuation Program, along with your completed Application.

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